Advance Directive: Durable Power of Attorney for Health Care

This advance directive, a durable power of attorney for health care, allows you to name and prepare your health care agent. This form meets the requirements of Washington state law.

My information:

FULL NAME: Spencer Joseph Barrett PRONOUNS (optional): he/they (i.e., he/she/they)

ADDRESS, CITY, STATE, ZIP: "Homeless" / Refugee Claimant / Minister

DATE OF BIRTH: 04/18/1994 (mm/dd/yyyy)

NAMING A HEALTH CARE AGENT

The person I designate as my health care agent is:

FULL NAME: Spencer Joseph Barrett PRONOUNS (optional): he/they

RELATIONSHIP: Self BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP: "Homeless" / Refugee Claimant / minister

The people I designate as my alternate agents are:

If the person listed above is unable or unwilling to make my health care decisions, then I designate the people listed below as my first and second alternate health care agents.

First alternate

FULL NAME: Danielle Patricia ~~Barr~~ Heck PRONOUNS (optional): She

RELATIONSHIP: Sister BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP: Corvallis Oregon 541 760 2183

Second alternate

FULL NAME: Alexandra Marie Van Stone PRONOUNS (optional): She

RELATIONSHIP: Sister BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP: Albany Oregon 541 760 2183

PREPARING A HEALTH CARE AGENT

Consider sharing the following. Be specific. Add pages if needed. Cross out any sections you prefer not to complete.

What matters most to me?

This section helps you think about what matters most to you. This information can guide the people who matter to you—like your health care agent and loved ones—to make health care decisions for you if you cannot make them yourself.

- **What do you love to do, mentally and physically, that you can't imagine living without (e.g., being able to care for yourself, staying in your own home, knowing who you are and who you are with, etc.)?**
  Backpacking, writing, visual arts
- **What do you value most in your life?** My Daughter Lucilia Roselyn Barrett, Transparency, Medical Rights "HIPAA", Human Rights, my Data/Records Public & Private

What are my beliefs, preferences, and practices?

It is important for the people who matter to you—like your health care agent and loved ones—and your health care team to know about your beliefs, preferences, and practices.

- **What provides you support, comfort, and strength during difficult times (e.g., touch, music, temperature, environment, who is in the room, etc.)?**
  Water, essential Amino acids (dairy) and all vitamins the above in moderate, interactive and responsive Dialogue/Dialectic/conversation
- **Are there medical treatments you would want or not want? (e.g., blood transfusion, pain management, artificial feeding, etc.)?**
  in Hierarchy from least invasive & most Naturopathic/"organic" to most invasive/synthetic
- **Do you have specific beliefs that you would like to guide your medical treatment?**
  yes, Unitarian Universalist, Hare Krsna pescatarian/Vegan Diet (if possible), all my publications FB, archive.org, YouTube, Instagram, Reddit, X, TikTok, et al

I would want the following person(s) contacted to support my beliefs, preferences, and practices: (They will not have power to make health care decisions.)

NAME: NO FRIENDS (r) ROLE: as defined by/in Jesus John 15:15

PHONE: ( ) ORGANIZATION:

I DO NOT WANT TO DIE INDOORS

WSMA Washington State Medical Association
Physician Driven, Patient Focused

PRINTED NAME: Spencer Joseph Barrett

DATE OF BIRTH: 04/18/1994 (mm/dd/yyyy)

Additional directions *(continued)*

Additional information you want your health care agent, health care team, or others to know about your health care wishes. You may include a statement such as "At the time of my death I am/am not an organ donor and my wish is… (e.g., cremation, burial, human composting, etc.)." Note that your wishes for organ donation and plans for your remains may be documented separately.

at the time of Death I am not an organ donor and my wish is for my body to decay on soil or area of Birds to eat

My agent shall have full authority to arrange and manage government benefits on my behalf, including but not limited to signing and ~~consenting to applications, contracts, ongoing eligibility review agreements, and care plans for federal aid, cash, food, medical,~~ housing, and long-term care benefits and services. (initial)

AUTHORIZING A HEALTH CARE AGENT

Authority I give my agent: I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to (a) consenting, refusing consent, and withdrawing consent for medical treatment recommended by my physicians, including life-sustaining treatments; (b) requesting particular medical treatments; (c) employing and dismissing members of the health care team; (d) changing my health care insurers; (e) signing a Portable Orders for Life-Sustaining Treatment (POLST) form; (f) transferring me to or placing me in another facility, private home, or other places; and (g) accessing my medical records and information.

I attest to the following: I understand the importance and meaning of this durable power of attorney for health care (DPOA-HC). This form reflects my health care agent choices and my goals, values, and preferences. I have filled out this form willingly. I am thinking clearly. I understand that I can change my mind at any time. I understand I can revoke and replace this form at any time. I revoke any prior durable power of attorney for health care. I want this DPOA-HC to become effective if a physician or licensed psychologist determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

MY SIGNATURE: Spencer Joseph Barrett DATE: 5/7/2026

Witnesses or notary requirement

You must have your signature either witnessed by two people or acknowledged by a notary public.

Rules for witnesses:

- ✓ Must be at least 18 years of age and competent.
- ⊘ Cannot be related to you or your health care agent by blood, marriage, or state-registered domestic partnership.
- ⊘ Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.
- ⊘ Cannot be your designated health care agent.

OPTION 1 – TWO WITNESSES

Witness attestation: I declare I meet the rules for being a witness.

WITNESS #1 SIGNATURE: DATE:

NAME PRINTED:

WITNESS #2 SIGNATURE: DATE:

NAME PRINTED:

OPTION 2 – NOTARY

STATE OF WASHINGTON)
COUNTY OF Whatcom)

This record was acknowledged before me on this 7th day of May, 2026

by (name of individual): Spencer Joseph Barrett

Signature: Spencer Joseph Barrett Title: Untitled "Sir" Exp:

WSMA Washington State Medical Association
Physician Driven, Patient Focused

PRINTED NAME: Spencer Joseph Barrett

DATE OF BIRTH: 04/18/1994 (mm/dd/yyyy)

PREPARING A HEALTH CARE AGENT

In answering the following questions, I am sharing my health care preferences. If I cannot make health care decisions for myself, I want my health care agent to use this information to guide their decisions. I understand that this information can guide my care, but it might not be possible to follow my wishes exactly in every situation.

CPR: What are my wishes?

Standard care in Washington state is to provide cardiopulmonary resuscitation (CPR) to people if their heart and breathing stop. This section can guide your health care agent and health care team on whether to perform CPR if you are hospitalized and your heart and breathing stop (also known as "code status").

If I am hospitalized and my heart and breathing stop:

- [x] I want CPR attempted.
- [ ] I want CPR attempted, unless there has been a change in my health, and I have:
  - Little chance of living a life that aligns with the goals and values I have stated in this form and/or discussed with my health care agent; or
  - A disease or injury that cannot be cured, and I am likely to die soon; or
  - Little chance of survival even if my heart is started again.
- [ ] I do not want CPR attempted. I want to be allowed to die naturally. *(Talk to your health care team about a POLST form.)*

Life support: What are my wishes?

Your response below is intended to guide your health care agent. Answering this question does not make this form a health care directive, which is a directive to withdraw or withhold life-sustaining treatment in specific situations under Washington state law. For more information on a health care directive, visit www.washingtonlawhelp.org or talk with your physician or health care team.

If I am so sick or injured that I am likely to die soon or am in a coma and unlikely to recover, I want my health care agent to: as natural as possible and least invasive, unless ABSOLUTELY NECESSARY to be peer reviewed by Zdr

- [x] Use all life-support treatments to keep me alive even if there is little chance of recovery. I want to stay on life support.
- [ ] Continue to try all life-support treatments that my health care team thinks might help extend my life (you can give a time frame for how long to continue to try all life support – days/weeks/months/years: _____). If the treatments do not work and there is little chance of living a life that aligns with my goals and values, I do not want to stay on life support. At that point, allow me to die naturally.
- [ ] Allow me to die naturally. I do not want to be on life support. If life-support treatments have been started, I want them to be stopped.
- [ ] I want my health care agent to decide for me.

Additional directions

If I am dying and my medical care, support system, and resources allow, my preference would be to die:

- [ ] At my home or the home of a loved one (with hospice if desired).
- [ ] In a medical facility.
- [ ] I do not have a preference.
- [x] Other (please describe): Outside Preferably Near Trees, Wildlife, & Running Water / creek or Ocean

continued >

PRINTED NAME: Spencer Joseph Barnett

DATE OF BIRTH: 04 / 18 / 1994
(mm/dd/yyyy)

PeaceHealth Financial Assistance Application Form - *CONFIDENTIAL*

Please provide answers to each question. If it does not apply, write "NA". Attach additional pages if needed.

PLEASE MAIL COMPLETED APPLICATION TO PEACEHEALTH, PO BOX 748632, LOS ANGELES, CA 90074-8632

Guarantor Number

SCREENING INFORMATION

Do you need an interpreter? ☐ Yes ☒ No *If Yes, list preferred language:* _____

Does the patient receive state public assistance services such as Medicaid, TANF, Basic Food, or WIC?? (OPTIONAL) ☐ Yes ☒ No

Is the patient currently homeless? ☒ Yes ☐ No Is the patient's medical care need related to a car accident or work injury? ☒ Yes ☐ No

PLEASE NOTE

- *We cannot guarantee that you will qualify for financial assistance, even if you apply.*
- *Once you send in your application, we may check all the information and may ask for additional information or proof of income.*

PATIENT AND APPLICANT INFORMATION

Patient First Name: Spencer | Patient Middle Name: Joseph | Patient Last Name: Barnett

☒ Male ☐ Female ☐ Other *May Specify:* | Birth Date: 04/18/1994 | Social Security Number (not required): 647-20-2350

Person Responsible For Paying Bill: Medicaid/Government | Relationship To Patient: Unconsensual Governing Authority (General Born Under) | Birth Date: 04/18/1994 | *Note: You do not have to provide a Social Security number to apply for financial assistance*

Mailing Address: _____ | Main Contact Number(s): ( ) _____

City: Whatcom | State: WA | Zip Code: _____

Email Address: endtheschism@gmail.com

Employment status of person responsible for paying bill

☐ **Employed** *Date of hire:* 04/18/1994 ☐ **Unemployed** *How long unemployed:* _____

☒ **Self-Employed** ☐ **Student** ☐ **Disabled** ☐ **Retired** ☐ **Other:** _____

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. **FAMILY SIZE** 8+ *Use additional paper if needed.*

Name	Date of Birth	Relationship to patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total GROSS monthly income (before taxes):	Also applying for financial assistance?
Seagulls					
Geese		Proximity	Seaweed & other	0/00	no
Ducks		"	Oats		"
Squirrel		"	Protein bar		"
Raccoon & Rats		"	trash		"

All adult family members' income must be disclosed and proof included with completed application. Examples of income sources include:

☐ Wages ☐ Unemployment ☐ Self-employment ☐ Workers Compensation ☐ Disability ☐ SSI ☐ Child/spousal support ☐ Work study programs (students) ☐ Pension ☐ Retirement account distributions ☐ Other *Please explain:* _____

ADDITIONAL INFORMATION

Please use additional pages if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

- I understand that PeaceHealth may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.
- I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.
- By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

Signature of Person Applying _____ Date 5/7/2026

If you have questions or need help completing this application: Please contact Customer Service at 1-877-202-3597. You may obtain help for any reason, including disability and language assistance. To view PeaceHealth's Financial Assistance Policy and additional information, please visit peacehealth.org.

PLEASE MAIL COMPLETED APPLICATION TO PEACEHEALTH, PO BOX 748632, LOS ANGELES, CA 90074-8632

Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at PeaceHealth.

PeaceHealth provides financial assistance in accordance with state and federal requirements to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income even if you have health insurance.

To view PeaceHealth's Financial Assistance Policy and additional information, please visit **peacehealth.org**.

What does financial assistance cover?
The hospital financial assistance covers appropriate hospital-based services provided by PeaceHealth depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Please contact Customer Service at 877-202-3597. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- Provide us information about your family.
- Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together).
- Provide us information about your family's gross monthly income (income before taxes and deductions).
- Provide documentation for family income.
- Attach additional information if needed.
- Sign and date the form.

Note: You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail, email or fax completed application with all documentation to: PeaceHealth Patient Financial Services, PO Box 748632, Los Angeles, CA 90074- 8632. Email: financialassistance@peacehealth.org Fax: (360) 729-3047. Be sure to keep a copy for yourself.

To submit your completed application in person: Please contact Customer Service for the closest drop-off location at 877-202-3597.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly! You may receive bills until we receive your information.

PeaceHealth

ver Joseph Daniel
atcom County, Bellingham WA, St. Joseph

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO 90 VANCOUVER WA

POSTAGE WILL BE PAID BY ADDRESSEE

ATTN: PATIENT FINANCIAL SERVICES (FAP)
PEACEHEALTH
1115 SE 164TH AVE DEPT 334
VANCOUVER WA 98683-9804

AFTER VISIT SUMMARY

PeaceHealth
The spirit of healing

Spencer J. Barrett MRN: 22241421 CEID: PH1-C58V-3QNC-HDZX

5/7/2026 St Joseph Emergency Department 360-734-5400

Instructions

As discussed your chest x-ray did demonstrate a nondisplaced fracture at the seventh rib on the left anterior chest wall. This is likely contributing to through the discomfort in the area. It will heal nicely on its own, can take up to 6 weeks for full healing. Have provided prescriptions for Tylenol and ibuprofen.

Your labs were unremarkable.

Please return for any questions or concerns.

Your medications have changed

START taking:
acetaminophen (TYLENOL)
ibuprofen (ADVIL,MOTRIN)

Review your updated medication list below.

Pick up these medications at WALGREENS DRUG STORE #07390 - BELLINGHAM, WA - 1070 E SUNSET DR AT SWC OF BARKLEY BLVD & SUNSET DR

acetaminophen • ibuprofen

Address: 1070 E SUNSET DR, BELLINGHAM WA 98226-3509
Phone: 360-647-2713

What's Next

You currently have no upcoming appointments scheduled.

Important Medication Refill Info

Please contact your primary care provider if you need refills for medications provided in the emergency department. If you are unable to follow up with your primary care provider or the referral given to you by the emergency department, and need additional medication treatment you will need to be seen by another medical provider. This can be done at an urgent care visit or via a return visit to the emergency department for evaluation.

Today's Visit

Reason for Visit

- Generalized Body Aches
- Muscle Pain

Diagnoses

- Chest wall muscle strain, initial encounter
- Mental health problem 1. thinks surveillance state exists
- Mental health problem 2. wants to kill father (consent vall for shit medicine)
- Closed fracture of one rib of left side, initial encounter

Lab Tests Completed

Drug Screen Rapid, Urine
Fentanyl Screen w/confirmation, Urine

Imaging Tests

EKG 12-lead Other: enter comment (chest wall pain)
XR RIBS LEFT AND PA CHEST 3+V

Blood Pressure 153/95	Temperature (Oral) 99.1 °F
Pulse 94	Respiration 18
Oxygen Saturation 97%	

Your Medication List

TAKE these medications

START

acetaminophen 500 MG tablet
Commonly known as: TYLENOL

Take 1 tablet (500 mg total) by mouth every 6 (six) hours as needed for Pain

START

ibuprofen 600 MG tablet
Commonly known as: ADVIL,MOTRIN

Take 1 tablet (600 mg total) by mouth every 6 (six) hours as needed for Pain

ASK your doctor about these medications

ASK

hydrocortisone-pramoxine rectal foam
Commonly known as: PROCTOFOAM-HC

Place 1 applicator rectally 2 (two) times daily as needed for Hemorrhoids or Pain

My PeaceHealth

Send Messages to your doctor, view your test results, renew your prescriptions, schedule appointments, and more.

Go to https://my.peacehealth.org/mypeacehealth/ , click "Sign Up Now".

St Joseph Emergency Department
2901 SQUALICUM PKWY
BELLINGHAM WA 98225
Phone: 360-734-5400

05/01/26 03:49	Latest Reference Ranges & Units	
138	136 - 145 mmol/L	**Sodium**
3.7	3.5 - 5.1 mmol/L	**Potassium**
104	98 - 111 mmol/L	**Chloride**
26	21 - 32 mmol/L	**CO2**
8	3 - 12 mmol/L	**Anion Gap**
10	9 - 23 mg/dL	**BUN**
0.71	0.70 - 1.30 mg/dL	**Creatinine**
111 ^	70 - 99 mg/dL	**Glucose**
125	>=60 mL/min/1.73m2	**eGFR (CKD-EPI 2021)**
7.3	5.7 - 8.2 g/dL	**Protein, Total**
3.8	3.4 - 5.0 g/dL	**Albumin**
3.5	2.2 - 3.5 g/dL	**Globulin**
9.6	8.7 - 10.4 mg/dL	**Calcium**
2.0	1.6 - 2.6 mg/dL	**Magnesium**
77	38 - 126 U/L	**Alkaline Phosphatase**
19	9 - 54 U/L	**ALT**
16	13 - 40 U/L	**AST**
0.5	0.3 - 1.2 mg/dL	**Bilirubin, Total**
3.082	0.550 - 4.780 uIU/mL	**TSH**

05/01/26 03:49	Latest Reference Ranges & Units	
86	49 - 397 U/L	CK
9.0	4.0 - 11.0 K/uL	WBC
4.56	4.31 - 5.77 M/uL	RBC
14.2	13.2 - 17.5 g/dL	HGB
41.4	38.9 - 49.9 %	HCT
90.8	80.0 - 100.0 fL	MCV
31.1	27.8 - 33.8 pg	MCH
34.3	31.5 - 36.5 g/dL	MCHC
13.2	11.5 - 14.2 %	RDW SD
257	150 - 400 K/uL	Plt Ct
8.3 ▼	8.5 - 12.4 fL	MPV
55.7	%	Neutrophil%
1.0	%	Imm Gran%
31.3	%	Lymphocytes %
7.7	%	Monocyte%
3.7	%	Eosinophil %
0.6	%	Basophil%
5.0	1.5 - 8.0 K/uL	Neutrophils#
0.1	0.0 - 0.1 K/uL	Imm Gran#
2.8	1.0 - 3.5 K/uL	Lymph#

05/01/26 03:49	Latest Reference Ranges & Units	
0.7	0.2 - 1.0 K/uL	**Monocytes#**
0.3	0.0 - 0.5 K/uL	**Eosinophils#**
0.1	0.0 - 0.2 K/uL	**Basophil#**
<5	<=30 ug/mL	**Acetaminophen**
<3	<30 mg/dL	**Salicylate (Aspirin)**
Negative	Negative (<0.010) g/dL	**Ethanol, Medical**
7.3	5.7 - 8.2 g/dL	**Protein, Total**
3.8	3.4 - 5.0 g/dL	**Albumin**
111 ▲	70 - 99 mg/dL	**Glucose**

AFTER VISIT SUMMARY

PeaceHealth
The spirit of healing

Spencer J. Barrett MRN: 22241421 CEID: PH1-C58V-3QNC-HDZX

5/1/2026 St Joseph Emergency Department 360-734-5400

Instructions

You were seen tonight for concerns about rectal prolapse. Your physical exam demonstrated an uncomplicated external hemorrhoid and associated skin tag but no current rectal prolapse. In any case, I doubt any medical emergency requiring immediate intervention or hospitalization at this time. I am prescribing a topical medication for relief of your symptoms, and I think you are safe for discharge. You can check your lab results on MyChart. Please return to the ER if your symptoms get much worse.

Your medications have changed

START taking:
hydrocortisone-pramoxine (PROCTOFOAM-HC)

Review your updated medication list below.

Read the attached information

Hemorrhoids (English)

Pick up these medications from any pharmacy with your printed prescription

hydrocortisone-pramoxine

Follow up with St Joseph Emergency Department

Why: If symptoms worsen
Specialty: Emergency Medicine
Contact: 2901 Squalicum Pkwy
Bellingham Washington 98225
360-734-5400

What's Next

You currently have no upcoming appointments scheduled.

Abbott

Today's Visit

Reason for Visit
Mental Health Crisis

Diagnoses

- Anal skin tag
- External hemorrhoids

Lab Tests Completed

Acetaminophen
Asymptomatic COVID PCR (formerly Rapid)
CBC with Differential
Comprehensive Metabolic Panel
Creatine Kinase, Total
Drug Screen Rapid, Urine
Ethanol (Alcohol), Medical
Fentanyl Screen w/confirmation, Urine
Magnesium
Salicylate
TSH Reflex to FT4 if Indicated
UA Dipstick, Reflex to Microscopic Exam and Culture

Blood Pressure 130/89	Temperature (Oral) 97.9 °F
Pulse 113	Respiration 20
Oxygen Saturation 98%	

March 27,2020
Abbot Diagnostics Scarborough, Inc.
FACT SHEET FOR PATIENTS - Coronavirus Disease 2019 (COVID-19)

You are being given this Fact Sheet because your sample(s) was tested for the Coronavirus Disease 2019 (COVID-19) using the ID NOW COVID-19 test. This Fact Sheet contains information to help you understand the risks and benefits of using this test for the diagnosis of COVID-19. After reading this Face Sheet, if you have questions or would like to discuss the information Provided, please talk to your healthcare provider.

- **For the most up to date information on COVID-19 please visit the CDC Coronavirus Disease 2019 (COVID-19) webpage:**
- **https://www.cdc.gov/COVID19**

What is COVID-19?
COVID-19 is caused by the SARS-CoV-2 virus. The virus, which can cause mild to severe respiratory illness, was first identified in Wuhan, China, and has now spread globally, including the United States. There is limited information available to characterize the spectrum of clinical illness associated with COVID-19 but it likely spreads to others when a person shows signs or symptoms of being sick (e.g., fever, coughing, difficulty breathing, etc.).

What is the ID NOW COVID-19 test?
The test is designed to detect the virus that causes COVID-19 in respiratory specimens, for example nasal or oral swabs.

Why was my sample tested? You were tested because your healthcare provider believes you may have been exposed to the virus that causes COVID-19 based on your signs and symptoms (e.g., fever, cough, difficulty breathing), and/or because:

- You live in or have recently traveled to a place where transmission of COVID-19 is known to occur, and/or
- You have been in close contact with an individual suspected of or confirmed to have COVID-19.

Testing of the samples will help find out if you may have COVID-19.

What are the known and potential risks and benefits of the test?
Potential risks include:

- Possible discomfort or other complications that can happen during sample collection.
- Possible incorrect test result (see below for more information).

Potential benefits include:

- The results, along with other information, can help your healthcare provider make informed recommendations about your care.
- The results of this test may help limit the spread of COVID-19 to your family and others in your community.

What does it mean if I have a positive test result?
If you have a positive test result, it is very likely that you have COVID-19. Therefore, it is also likely that you may be placed in isolation to avoid spreading the virus to others. There is a very small chance that this test can give a positive result that is wrong (a false positive result). Your healthcare provider will work with you to determine how best to care for you based on the test results along with medical history, and your symptoms.

What does it mean if I have a negative test result?
A negative test result means that the virus that causes COVID-19 was not found in your sample. For COVID-19, a negative test result for a sample collected while a person has symptoms usually means that COVID-19 did not cause your recent illness.

However, it is possible for this test to give a negative result that is incorrect (false negative) in some people with COVID-19. This means that you could possibly still have COVID-19 even though the test is negative. If this is the case, your healthcare provider will consider the test result together with all other aspects of your medical history (such as symptoms, possible exposures, and geographical location of places you have recently traveled) in deciding how to care for you.

It is important that you work with your healthcare provider to help you understand the next steps you should take.

Is this test FDA-approved or cleared?
No. This test is not yet approved or cleared by the United States FDA. When there are no FDA-approved or cleared tests available, and other criteria are met, FDA can make tests available under an emergency access mechanism called an Emergency Use Authorization (EUA). The EUA for this test is supported by the Secretary of Health and Human Service's (HHS's) declaration that circumstances exist to justify the emergency use of in vitro diagnostics for the detection and/or diagnosis of the virus that causes COVID-19. This EUA will remain in effect (meaning this test can be used) for the duration of the COVID-19 declaration justifying emergency of IVDs, unless it is terminated or revoked by FDA (after which the test may no longer be used).

© 2020 Abbott. All rights reserved. All trademarks referenced are trademarks of either the Abbott group of companies or their respective owners.

- TB000038 Rev. 2

Where can I go for updates and more information? The most up-to-date information on COVID-19 is available at the CDC General webpage: **https://www.cdc.gov/COVID19.** In addition, please also contact your healthcare provider with any questions/concerns.

Important Medication Refill Info

Please contact your primary care provider if you need refills for medications provided in the emergency department. If you are unable to follow up with your primary care provider or the referral given to you by the emergency department, and need additional medication treatment you will need to be seen by another medical provider. This can be done at an urgent care visit or via a return visit to the emergency department for evaluation.

Your Medication List

START

hydrocortisone-pramoxine rectal foam
Commonly known as: PROCTOFOAM-HC

Place 1 applicator rectally 2 (two) times daily as needed for Hemorrhoids or Pain

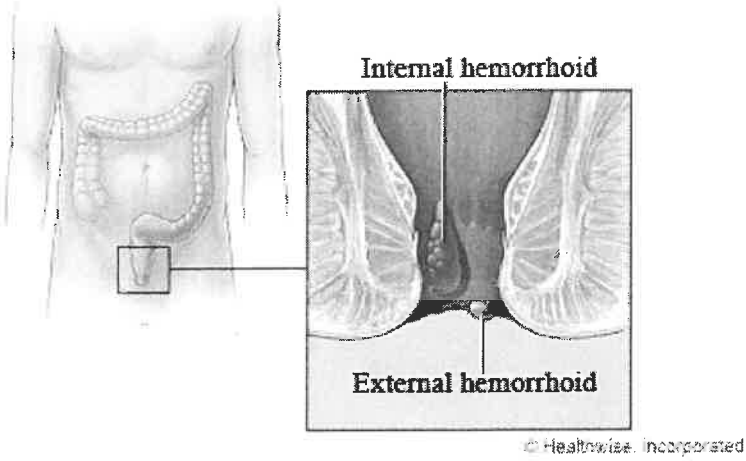
My PeaceHealth

Send Messages to your doctor, view your test results, renew your prescriptions, schedule appointments, and more.

Go to https://my.peacehealth.org/mypeacehealth/ , click "Sign Up Now".

Hemorrhoids: Care Instructions

Overview



© Healthwise, Incorporated

Hemorrhoids are swollen veins that develop in the anal canal. Bleeding during bowel movements, itching, and rectal pain are the most common symptoms. Hemorrhoids can be uncomfortable at times, but rarely are they a serious problem.

Most of the time, you can treat them with simple changes to your diet and bowel habits. These changes include eating more fiber and not straining to pass stools. Most hemorrhoids don't need surgery or other treatment unless they are very large and painful or bleed a lot.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

How can you care for yourself at home?

- Sit in a few inches of warm water (sitz bath) 3 times a day and after bowel movements. The warm water helps with pain and itching.
- Put ice on your anal area several times a day for 10 minutes at a time. Put a thin cloth between the ice and your skin. Follow this by placing a warm, wet towel on the area for another 10 to 20 minutes.
- Take pain medicines exactly as directed.
  - If the doctor gave you a prescription medicine for pain, take it as prescribed.
  - If you are not taking a prescription pain medicine, ask your doctor if you can take an over-the-counter medicine.
- Keep the anal area clean, but be gentle. Use water and a fragrance-free soap, or use baby wipes or medicated pads such as Tucks.
- Wear cotton underwear and loose clothing to decrease moisture in the anal area.
- Eat more fiber. Include foods such as whole-grain breads and cereals, raw vegetables, raw and dried fruits, and beans.
- Drink plenty of fluids. If you have kidney, heart, or liver disease and have to limit fluids, talk with your doctor before you increase the amount of fluids you drink.

- Use a stool softener that contains bran or psyllium. You can save money by buying bran or psyllium (available in bulk at most health food stores) and sprinkling it on foods or stirring it into fruit juice. Or you can use a product such as Metamucil or Hydrocil.
- Practice healthy bowel habits.
  - Go to the bathroom as soon as you have the urge.
  - Avoid straining to pass stools. Relax and give yourself time to let things happen naturally.
  - Do not hold your breath while passing stools.
  - Do not read while sitting on the toilet. Get off the toilet as soon as you have finished.
- Take your medicines exactly as prescribed. Call your doctor if you think you are having a problem with your medicine.

When should you call for help?

Call 911 anytime you think you may need emergency care. For example, call if:

- You pass maroon or very bloody stools.

Call your doctor now or seek immediate medical care if:

- You have increased pain.
- You have increased bleeding.

Watch closely for changes in your health, and be sure to contact your doctor if:

- Your symptoms have not improved after 3 or 4 days.

Where can you learn more?

Go to My PeaceHealth at **https://my.peacehealth.org** to log on. Select the Resources menu and select Search Medical Library to enter **F228** in the search box to learn more about "**Hemorrhoids: Care Instructions**."

Not on My PeaceHealth? Go to **my.peacehealth.org** and click the "Sign up Now" link to enter the activation code included in this After Visit Summary.

Current as of: October 6, 2025
Content Version: 14.8

© 2024-2025 Ignite Healthwise, LLC.
Care instructions adapted under license by PeaceHealth. If you have questions about a medical condition or this instruction, always ask your healthcare professional. Ignite Healthwise, LLC disclaims any warranty or liability for your use of this information.

St Joseph Emergency Department
2901 SQUALICUM PKWY
BELLINGHAM WA 98225
Phone: 360-734-5400

Whatcom County Primary Care Offices

PeaceHealth Medical Group

To establish care, call the Patient Service Center at (360)752-5628, or visit www.peacehealth.org for more information

PeaceHealth Medical Group
4545 Cordata Parkway
Bellingham, WA 98226
(360) 738-2200

PeaceHealth Center for Senior Health
3015 Squalicum Parkway, Ste 100
Bellingham, WA 98225
(360) 715-4186

Family Care Network

www.familycarenetwork.com

Birch Bay Family Medicine
8097 Harborview Rd
Blaine, WA 98230
(360) 371-5855

Family Health Associates
3500 Orchard Place
Bellingham, WA 98225
(360) 671-3900

Ferndale Family Medical Center
5580 Nordic Way
Ferndale, WA 98248
(360) 384-1511

Squalicum Family Medicine
3015 Squalicum Parkway Suite 120
Bellingham, WA 98225
(360) 676-9336

Lynden Family Medicine
1610 Grover Street Suite D1
Lynden, WA 98264
(360) 354-1333

North Sound Family Medicine
2075 Barkley Boulevard, Suite 105
Bellingham, WA 98226
(360) 671-3345

Whatcom Family Medicine
3015 Squalicum Parkway Suite 160
Bellingham, WA 98225
(360) 671-4402

Bellingham Bay Family Medicine
722 N. State Street
Bellingham, WA 98225
(360) 752-2865

Unity Care NW

www.unitycarenw.org

Bellingham Health Center
220 Unity Street
Bellingham, WA 98225
(360) 676-6177

Ferndale Health Center
6060 Portal Way
Ferndale, WA 98248
(360) 752-741

SeaMar Community Health Center

www.seamar.org

Bellingham Health Center
4455 Cordata Parkway
Bellingham, WA 98226
(360) 671-3225

Everson Health Center
6884 Hannegan Rd
Everson, WA 98247
(360) 354-0766

Associates in Family Medicine

www.associatesinfamilymedicine.com
3130 Ellis St, Bellingham, WA 98225
(360) 734-4404

Bellingham Family Health Clinic

www.bellinghamhealth.com
Functional Med & Women's Health only
1050 Larrabee Ave, Suite 204,
Bellingham, WA 98225
(360) 756-9793

Care Medical Group

www.caremg.com
Additional services: Urgent Care, Physical Therapy, Occupational Therapy
4043 Northwest Ave
Bellingham, WA 98226
(360) 734-4300
M-F 8a-7p, Sat/Sun 9a-4p

Same-Day Clinics/Urgent Care

PeaceHealth Medical Group

-**Fairhaven Plaza:** 3125 Old Fairhaven Parkway, Suite 106, (360) 788-8388
M-F 8a-5p, closed Sat/Sun
-**Cordata Main:** 4545 Cordata Pkwy, Suite 1A, (360) 788-8180
M-F 9a-5p, closed Sat/Sun
-**Medical Office Plaza:** 3015 Squalicum Pkwy Suite 140, (360) 788-8420
M-F 8a-8p, Sat/Sun 8a-6p

Family Care Network

-**Bellingham:** 3130 Squalicum Parkway, (360) 671-4509
M-F 1p-9p, Sat/Sun 9a-5p
-**Lynden:** 1610 Grover Street, Suice D-1, (360) 354-4567
M-F 1p-9p, Sat/Sun 9a-5p
-**Mount Vernon:** 205 Stewart Rd, Suite 104, (360) 395-2938
M-F 3p-9p, Sat/Sun 9a-5p

Super Track Urgent Care

supertrackurgentcare.com
-**Lakeway:** 1050 Lakeway Drive, (360) 746-6531
M-F 10a-6p, Sun 10a-4p, closed Sat

As a PeaceHealth patient, you have the following rights:

Dignity, respect, and compassion

- To be treated and cared for with dignity and respect.
- To reasonable access to care, treatment and/or accommodations that are available or medically advisable regardless of one's race, color, ethnicity, national origin (including limited English proficiency and primary language), creed, culture, religion, sex (including pregnancy), sex characteristics, sexual orientation, gender identity or expression, physical or mental disability, age, status as a disabled veteran, having an Advance Directive or ability to pay for care (socioeconomic status). Discrimination on the basis of any of the above is prohibited.
- To express your values and beliefs and to exercise spiritual and cultural beliefs that do not interfere with delivery of patient care and the well-being of others.
- To care that is considerate and respectful of your cultural and personal values and beliefs.
- To have a family member, including a registered domestic partner, surrogate decision-maker, and your own doctor (if requested) notified promptly of your admission to the hospital.
- To appoint a surrogate to make healthcare decisions on your behalf to the extent permitted by law.
- To be informed of your healthcare needs and the alternatives for care when a hospital cannot provide the care you request. If it is medically advisable, you may be transferred to an appropriate and acceptable facility.

Quality Care and Safety

- You, along with your family, including a registered domestic partner and/or your legally authorized decision-maker(s), have the right, in collaboration with your doctor, to be informed and make decisions involving your healthcare, including resolving problems with care, the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
- To be informed of outcomes of care, treatment, and services, including unanticipated outcomes.
- To effective pain management. Pain will be assessed and managed as deemed medically appropriate.
- To receive care in a reasonably safe and secure environment.
- To be free from all forms of abuse, neglect, exploitation, or harassment.
- To be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience or retaliation. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time.
- To know that, to enhance patient safety, video or auditory monitoring may be done in some individual patient rooms, care areas, or common areas.

Meaningful Interactions and information

- Reasonable access to an interpreter if you do not speak or understand the English language, at no charge.
- To receive information that accommodates for issues with vision, speech, hearing, or other special needs.
- Access to your own health information, to request amendment to it, and to request and receive an accounting of disclosures about it, as permitted under applicable law.
- Consideration of your personal privacy and confidentiality of information (examples: you may request that communication about your health information be made available at alternative locations; request that your PHI not be shared with a previous provider; request that certain disclosures of your health information be restricted; or request to restrict disclosure of PHI about yourself to a health plan if you are planning to self-pay in full prior to the service).
- If a Medicare beneficiary, to receive notice of non-coverage and your rights to appeal a premature discharge.

Personal Care

- To know the name of the doctor and other practitioners who have primary responsibility for your care, and to know the identity and professional status of individuals responsible for authorizing and performing procedures and care.
- To have reasonable access to people outside the medical center by means of visitors, and by verbal and written communication.
- Subject to your consent, to receive visitors you designate, including but not limited to a spouse, domestic partner, another family member, or a friend, and have the right to withdraw or deny such consent at any time. Such access is permitted so long as it does not interfere with the provision of patient care services and a reasonably safe and secure environment. Any restrictions on communication are fully explained to you and/or family. Visitation privileges are not restricted, limited, or denied on the basis of race, color, creed, religion, sex, sexual orientation, gender identity, national origin, disability, or age. Visitors enjoy full and equal visitation privileges consistent with patient preferences.
- To formulate advance directives about end-of-life decisions and mental health treatment and have the hospital follow those directives to the extent allowable by hospital policy, state, and federal law.
- To not participate in investigative studies and to be informed of alternative care options.
- To participate in ethical questions and concerns that arise during your care. You or your family members may request an ethics consultation regarding issues of conflict resolution, withholding resuscitative services, foregoing or withdrawing life-sustaining treatment, and participating in investigational studies or clinical trials, and other ethical concerns.
- To have access to spiritual care.

- To request and receive an itemized and detailed explanation of the bill for services rendered.

As a PeaceHealth patient, your responsibilities are:

- To provide, to the best of your knowledge, accurate and complete information and to report any changes in your condition to their practitioner. You have the responsibility to participate in discussions and to ask questions about your plan of care.
- To inform the care team if you do not clearly understand a proposed course of action and what is expected of you.
- To notify your healthcare providers when a cultural situation exists concerning the healthcare process.
- To inform the care team if you have special needs.
- To initiate and follow through on recommended treatment plans. As active participants in your health care, you or your caregivers are responsible for contacting providers if you have questions or are unclear about the treatment plan, or why those next steps are critical toward achieving positive health outcomes.
- To take care of your personal belongings. This includes, but is not limited to, dentures, eyeglasses, crutches, wheelchairs, and personal items such as jewelry. The healthcare facility is not responsible if these items are damaged or misplaced while here.
- To be responsible for the following rules affecting patient care and conduct:
  - Do not disturb other patients.
  - Do not disrupt or interfere with care provided to other patients and the operations of the healthcare facility.
  - Do not conduct any illegal activities on the premises of the healthcare facility.
  - Do not smoke, vape, or use tobacco products on the healthcare facility campus.
  - Do not verbally or physically assault staff, faculty, or providers.
- To provide accurate personal identification information.
- To provide updated financial information and meet any financial obligation to the healthcare facility.
- To be considerate of the rights of other patients and healthcare facility personnel. Threats, violence, disrespectful communication, or harassment of other patients or of any healthcare facility staff member, for any reason, including because of an individual's race, color, creed, religion, sex, sexual orientation, gender identity or expression, ethnicity, national origin, disability, age or veteran or military status, or other aspect of difference will not be tolerated. This prohibition applies to you as well as to your family members, representative and visitors. In addition, requests for changes of provider or other medical staff based on that individual's race, ethnicity, religion, sexual orientation, or gender identity will not be honored. Requests for provider or medical staff changes based on gender will be considered on a case-by-case basis and only based on extenuating circumstances.
- To be respectful of the property of other persons and the healthcare facility.

You have the right to make complaints about your care and receive a timely response according to established policy. Patients can freely voice complaints and recommend changes without fear of retribution or denial of care. Ask to speak to the charge nurse, the department manager, or contact one of PeaceHealth's Risk Management team members using the phone numbers provided below. You may also file a grievance with the state or with Medicare without fear of reprisal.

PeaceHealth St. Joseph Medical Center 2901 Squalicum Parkway Bellingham, WA 98225 360-734-5400 **Patient Relations Team** 1-844-749-8817	**PeaceHealth Peace Island Medical Center** 1117 Spring Street Friday Harbor, WA 98250 360-378-2141 **Patient Relations Team** 1-844-749-8817	**PeaceHealth United General Medical Center** 2000 Hospital Drive Sedro-Woolley, WA 98284 360-856-6021 **Patient Relations Team** 1-844-749-8817
PeaceHealth St. John Medical Center 1615 Delaware Street Longview, WA 98632 360-414-2000 **Patient Relations Team** 1-844-749-8817	**PeaceHealth Southwest Medical Center** 400 NE Mother Joseph Place Vancouver, WA 98664 360-514-2000 **Patient Relations Team** 1-844-749-8817	**PeaceHealth Medical Group** All Locations **Patient Relations Team** 1-844-749-8817
Washington Department of Health Online: https://doh.wa.gov/licenses-permits-and-certificates/file-complaint-about-provider-or-facility/complaint-forms By mail: **Washington State Department of Health** Health Systems Quality Assurance Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857 Email: HSQAComplaintIntake@doh.wa.gov		**Center for Medicare and Medicaid Services (CMS)** **Medicare Beneficiary Ombudsman** Online: www.medicare.gov/providers-services/claims-appeals-complaints/complaints https://www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home Toll free: 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048

Filled 5/7/2026

What can a health care agent do?

If you cannot make your own health care decisions, your health care agent will be asked to make health care decisions for you. Your health care agent can use the information you share in this advance directive and in conversations to guide your care.

Consistent with state law and using their understanding of your goals, values, and preferences, your health care agent can:

- Decide on treatments and surgeries, including whether to use cardiopulmonary resuscitation (CPR), a breathing machine, a feeding tube, and other treatments.
- Decide whether to end life-support treatment and focus on comfort care.
- Review and release medical records for your care and apply for health care insurance benefits on your behalf.
- Choose the health care professionals and organizations to provide your health care.

What is CPR?

Cardiopulmonary resuscitation, or CPR, is a procedure used when your heart and breathing stop. CPR works best if your body is healthy and CPR is started right away after your heart stops. CPR is less likely to be successful if you are weak, elderly, or have a serious illness.

If you survive, you might need a ventilator (breathing machine) because of weakened lungs. It is important to talk to your physician and health care team about whether CPR would meet your goals.

Standard care in Washington state is to provide CPR to people if their heart and breathing stop. Sharing your CPR wishes on this DPOA-HC form can guide your "code status" if you are hospitalized. Code status means the type of emergent treatment a person would or would not receive in the hospital if their heart or breathing stop.

Some people who choose not to receive CPR in a hospital also do not want CPR in other settings. In this situation you should ask your physician or other member of the health care team about completing a Portable Orders for Life-Sustaining Treatment, or POLST. POLST is a medical order

What happens if I do not name a health care agent?

If you cannot make your own health care decisions and a health care agent is not named, your health care team will follow Washington state law to determine who can act as your medical decision-maker. This means they will ask family members or friends to make health care decisions for you. If family or friends cannot be identified from the list below, your physician or other member of the health care team may ask a court to appoint a guardian to make health care decisions on your behalf.

Your health care team will contact people in the following order until they can identify a medical decision-maker for you (chapter 7.70.065 RCW).

1. A guardian appointed by a court (if applicable)
2. Named health care agent(s)*
3. Spouse or registered domestic partner
4. Adult children*

If you are not naming a health care agent in this form

Although a primary goal of this form is to name a health care agent, you have the option not to name one. If a health care agent is not named, your health care team will follow Washington state law to determine who can act as your medical decision-maker (chapter 7.70.065 RCW).

If you complete the other sections of this form, it will be considered a personal values statement and not an advance directive. A personal values statement is a summary of your goals, values, and preferences. This information can guide your medical decision-maker on how to make decisions on your behalf.

In this situation, you may also consider completing a health care directive, also known as a living will, which is a directive to withdraw or withhold life-sustaining treatment in specific situations under Washington state law. For more information on a health care directive, visit www.washingtonlawhelp.org or talk with your physician or health care team.

What should I do with this advance directive?

Once you complete this advance directive, you should talk about your wishes and give copies to the people who matter to you—like your health care agent and loved ones—and your health care team, clinic, and hospital. If it applies, consider sharing copies with your nursing home or assisted living facility too. It is important that everyone has a copy.

What if I change my mind?

If you change your mind about the decisions in your advance directive, tell everyone who has a copy, including your health care agent, loved ones, health care team, clinic, and hospital. You can revoke or void your advance directive at any time. You will need to tell your physician or other member of the health care team that you want to revoke it either by writing them a letter (make sure to sign and date it) or by verbally telling them. It is important to complete a new advance directive. Be sure to give copies of the new advance directive to the people who matter to you—like your health care agent and loved ones—and your health care team, clinic, and hospital.

What about organ and tissue donation?

Indicate your decisions regarding organ, tissue, and eye donation at www.donatelifetoday.com, then inform your health care agent, family, and health care team of your choice. Registering to be a donor is a legally binding decision.

What about decisions for after death?

The authority of those named in a DPOA-HC ends at time of death. For more information on how to guide decisions after death and to document how you want your body cared for when you die, visit www.washingtonfuneral.org or speak to a local funeral home or hospice agency.

Who can I contact if I need help with advance care planning?

If you need support with advance care planning contact your health care team.

Filled 5/7/2026

Advance Care Planning

Make your healthcare wishes known before a crisis. It's one of the best gifts you can give yourself and those around you.

What is advance care planning?

Advance care planning is deciding the kind of care you want to receive if you're ever unable to speak for yourself. Making these decisions ahead of time means others know how to honor your preferences.

Discuss possible scenarios with your loved ones and healthcare providers. Put your wishes down on paper. This will help your medical team, family and friends know what you want. Having clear plans in writing reduces the chance that people will be confused. In times of crisis, it can lessen possible misunderstandings or conflicts.

What is an advance directive?

An advance directive includes:

- A durable power of attorney for health care. This lets you name a person, called a healthcare agent/ representative, to make treatment decisions for you when you can't speak for yourself.
- A living will. This is also known as a health care directive. This tells your family and doctor what kinds of treatment you want to receive in certain medical scenarios.

What is a POLST form?

A Portable Order for Life Sustaining Treatment (POLST) is an out of hospital medical order signed by your medical provider that explains what kind of care you want to have in a serious, life-threatening event. It is used to share medical care decisions with healthcare professionals and emergency responders.

If you are interested in talking more about a POLST, please schedule time with your medical provider.

Where do I get an advance directive?

You are encouraged to use the approved advance directive from the state in which you live — even if you receive medical care in another state.

The following website is where you can get a copy of the most commonly used document for your state:

www.peacehealth.org/advance-care-planning

Here you will also find more information about advance care planning and can sign up for a **FREE** class or contact our ACP team for support.

To get your completed documents on file:

Once you have a plan, let others know about it. You can add it to your medical record, where healthcare providers and others can easily find it.

- Bring a copy of your documents to any PeaceHealth clinic.
- Upload through MyPeaceHealth portal
- Fax to: 360-729-3444
- Scan and mail:
  RSSYS-PeaceHealthACP@peacehealth.org
- Mail a copy of your document to:
  PeaceHealth
  Attention: Health Information Management
  1115 SE 164th Ave., Dept. 336
  Vancouver, WA 98683

Reach out to our Advance Care Planning team through our website:
peacehealth.org/advance-care-planning

Peace Health

What is advance care planning?

Advance care planning is thinking about what health care you might want in the future. This type of planning includes talking about, writing down, and sharing what is important to you. This helps others make health care decisions for you if you cannot make your own decisions. In this situation, a person close to you would need to make decisions for you. This person is called a health care agent, also known as an attorney-in-fact, surrogate, or legal medical decision-maker.

It is important that you prepare your health care agent by sharing your completed documents and how you would want them to make health care decisions for you.

What is an advance directive?

An advance directive is a voluntary, legal way to write down your advance care planning decisions. You should share your advance directive with people who matter to you—like your health care agent and loved ones—and your physician, health care team, clinic, and hospital. An advance directive should be updated regularly. All adults 18 and older can complete an advance directive.

There are two types of advance directives in Washington state: 1) a durable power of attorney for health care and 2) a health care directive.

The Washington State Medical Association advance directive is a durable power of attorney for health care, or DPOA-HC. The DPOA-HC is based on Washington state law (chapter 11.125 RCW). This legal form allows you to name your health care agent to make health care decisions for you if you cannot make your own decisions. This form also helps you prepare your health care agent by sharing your goals, values, and preferences. Research shows that the best way to ensure your wishes are followed is to name and prepare a health care agent.

The health care directive is based on Washington state law (chapter 70.122 RCW). Health care directives are also known as living wills. You may consider also completing a health care directive, which is a directive to withdraw or withhold life-sustaining treatment in specific situations under Washington state law. Visit the Northwest Justice Project at www.washingtonlawhelp.org for more information on the health care directive or talk with your physician or health care team.

What is a health care agent?

A health care agent is the person you choose to make health care decisions for you if you cannot make them for yourself. You should tell your health care agent what is important to you, like your personal values and goals for treatment. This information can guide your health care agent, physician, and health care team to make the best possible decisions on your behalf if you cannot make your own decisions. By completing this advance directive (a durable power of attorney for health care) you allow this person to make decisions with your physician and health care team about your care. Your health care agent will not be personally financially responsible for care they select for you as your health care agent.

What makes a good health care agent?

Your health care agent SHOULD:

- ☑ Understand what a health care agent does and be willing to fill this role.
- ☑ Share your goals, values, and preferences with your health care team, and describe what "living well" or a "good day" means to you.
- ☑ Carry out your decisions, even if they do not agree with your decisions.
- ☑ Be able to make decisions in difficult or stressful times.

Your health care agent CANNOT be:

- ⊘ Under 18 years old.
- ⊘ Your physician or your physician's employee (unless they are your spouse, state-registered domestic partner, parent, adult child, or adult sibling).
- ⊘ An owner, administrator, or employee of a health care facility or long-term care facility where you receive care or live (unless they are your spouse, state-registered domestic partner, parent, adult child, or adult sibling).